VOLUNTEER HEALTH & REGISTRATION FORM

THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND NOTARIZED IF THE COUNSELOR IS UNDER 18 YEARS OF AGE.

COUNSELORS OVER THE AGE OF 18 MUST SIGN THIS FORM.

VOLUNTEER COUNSELOR INFORMATION

LAST NAME _____ **FIRST NAME** _____ **INITIAL** _____

PARENT/GUARDIAN INFORMATION

Last Name _____ First Name _____ Initial _____

Address _____ Apt. # _____

City _____ State ____ Zip _____ Home Telephone _____

Spouse Name _____ Bus. Telephone _____

Cell Phone _____

IF PARENT/GUARDIAN IS NOT AVAILABLE IN EMERGENCY, NOTIFY

Emergency Contact _____ Telephone _____

Relationship to Volunteer _____ Cell Phone _____

CONSENT RELEASE

In signing this release, I certify that the information provided on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by The Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for myself (son/daughter), as named herein. I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by myself (son/daughter) at on-site camps and supervise the First Aid personnel of off-site camps in the distribution of medicines. I give permission for myself (son/daughter) to be transported in The Warwick Conference Center vehicles or other designated vehicles to and from public transportation. I give permission for myself (son/daughter) to be transported by public transportation as necessary for approved off-site camp activities. I authorize the use of photographs of myself (son/daughter) in camp publicity.

_____ _____

PARENT/GUARDIAN* OR VOLUNTEER** SIGNATURE DATE

ACKNOWLEDGEMENT BY INDIVIDUAL

STATE OF) SS:

COUNTY OF)

On this (day) _____ (month of) _____, (year)_____, before me personally came _____, to me known and known to me to be the person described in and who executed the forgoing instrument and he/she acknowledged to me that he/she executed the same.

_____

Notary Public

**If you are under 18 years of age, your parent/guardian must sign this form, and have it notarized.*

***If you are a volunteer over the age of 18, you must personally sign this form, but you do not need to have it notarized.*

(COMPLETE HEALTH INFORMATION ON REVERSE SIDE)

VOLUNTEER COUNSELOR HEALTH INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth _____/_____/_____ Age _____ ❑ Male ❑ Female

Date of Last Physical Exam _____/_____/_____

Physician/Clinic _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____

Health Insurance Co. _____ Policy # _____

Health Insurance Co. Phone #_____ Please attach copy of insurance card (front & back)

IMMUNIZATION RECORD

Please provide an OFFICIAL IMMUNIZATION RECORD from your doctor's office. Include a verification of your most recent TB test.

ALLERGIES

Asthma	❑ Yes ❑ No	Sulpha	❑ Yes ❑ No
Bee Sting	❑ Yes ❑ No	Suntan Lotion	❑ Yes ❑ No
Hay Fever	❑ Yes ❑ No	Poison Ivy/Oak/	
Penicillin	❑ Yes ❑ No	Sumac	❑ Yes ❑ No

Other: _____

FOOD ALLERGIES *(Please list)*

_____

_____

MEDICATIONS

I give permission to the Camp Warwick Health Director to supervise and/or administer the following medications (check off):

_____ Antacids
_____ Aspirin
_____ Cold Medications
_____ Cough Syrup
_____ External Ointments
_____ Suntan Lotion
_____ Tylenol
_____ Other over-the-counter medications (list):
_____
_____
_____

MEDICAL INFORMATION

Are you in general good health and able to participate in all normal camp activities? ❑ Yes ❑ No
If no, please explain on a separate sheet of paper.

ADD	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No
ADHD	❑ Yes ❑ No	Homesickness	❑ Yes ❑ No
Ear Infections	❑ Yes ❑ No	Hyperactive	❑ Yes ❑ No
Diabetic	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Seizure Disorders	❑ Yes ❑ No		

List any of the following:
Chronic-recurring illness _____
Convulsive disorders _____
Recent illness/injury _____
Contagious diseases _____

Please submit statement of how you have been treated and with what medication.

Serious operations *(list date/type):* _____
_____
_____
_____

Please list all prescription medications you are currently taking. Include the dosage & instructions for use.

_____
_____
_____
_____
_____

Prescription drug policy? ❑ Yes ❑ No *If yes, attach a photocopy of the card (front and back).*

The HEALTH DIRECTOR will supervise the self-medication of prescription and over-the-counter medicines by counselors at on-site camps and supervise the First Aid personnel while off-site in the distribution of medicine. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. **ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE IN THE ORIGINAL CONTAINER, LABELED WITH THE COUNSELOR'S NAME AND WRITTEN INSTRUCTIONS SIGNED BY YOUR PHYSICIAN ATTACHED. ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE GIVEN TO THE HEALTH DIRECTOR**

Please keep a copy of this form for future reference.